

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN4709	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/28/2013
NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, FT SANDERS			STREET ADDRESS, CITY, STATE, ZIP CODE 2120 HIGHLAND AVE KNOXVILLE, TN 37916		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 002	1200-8-6 No Deficiencies During annual Licensure survey and complaint investigation #31595, conducted from August 26, 2013, through August 28, 2013, at NHC Fort Sanders, no deficiencies were cited under 1200-8-6, Standards for Nursing Homes.	N 002	No response required		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

ZN3U11

If continuation sheet 1 of 1

Douglas S. Ford
N.H.A.

9/5/13

SEP 05 2013